(2) Reports for use by classes of purchasers, who purchase from certified health plans, health care payers, and providers as specified for content and format in the state-wide data system and data plan;

(3) Reports on relevant health care policy including the distribution of hospital charity care obligations among hospitals; absolute and relative rankings of Washington and other states, regions, and the nation with respect to expenses, net revenues, and other key indicators; provider efficiencies; and the effect of medicare, medicaid, and other public health care programs on rates paid by other purchasers of health care; and

(4) Any other reports the commission or department deems useful to assist the public or purchasers of certified health plans in understanding the prudent and cost-effective use of certified health plan services. [1993 c 492 § 260; 1989 1st ex.s. c 9 § 511.]

NOTES:

Additional reporting requirements--Study--1993 c 492: "The commission shall determine, by January 1, 1995, the necessity, if any, of reporting requirements by the following health care entities: Health care providers, health care facilities, insuring entities, and certified health plans. The reporting requirements, if any, shall be for the purposes of determining whether the health care system is operating as efficiently as possible. Information reported pursuant to this section shall be made available to interested parties upon request. The commission shall report its findings to the legislature by January 1, 1995." [1993 c 492 § 264.]

Findings--Intent--1993 c 492: See notes following RCW 43.72.005.

Short title--Severability--Savings--Captions not law--Reservation of legislative power--Effective dates--1993 c 492: See RCW 43.72.910 through 43.72.915.

RCW 70.170.120 Confidentiality of data. (1) Notwithstanding the provisions of chapter 42.17 RCW, any material contained within the state-wide health care data system or in the files of either the department or the Washington health services commission shall be subject to the following limitations: (a) Records obtained, reviewed by, or on file that contain information concerning medical treatment of individuals shall be exempt from public inspection and copying; and (b) any actuarial formulas, statistics, and assumptions submitted by a certified health plan to the commission or department upon request shall be exempt from public inspection and copying in order to preserve trade secrets or prevent unfair competition.

(2) All persons and any public or private agencies or entities whatsoever subject to this chapter shall comply with any requirements established by rule relating to the acquisition or use of health services data and maintain the confidentiality of any information that may, in any manner, identify individual persons.

(3) Data collected pursuant to RCW 70.170.130 and 70.170.140 shall be used solely for the health care reform provisions of

chapter 492, Laws of 1993. The department shall ensure that the enrollee identifier used will employ the highest available standards for accuracy and uniqueness.

(4) Nothing in this section shall impede an enrollee's access to her or his health care records as provided in chapter 70.02 RCW. [1993 c 492 § 261.]

NOTES:

Findings--Intent--1993 c 492: See notes following RCW 43.72.005.

Short title--Severability--Savings--Captions not law--Reservation of legislative power--Effective dates--1993 c 492: See RCW 43.72.910 through 43.72.915.

RCW 70.170.130 Health services commission access to data. The Washington health services commission shall have access to all health data available to the secretary of health. To the extent possible, the commission shall use existing data systems and coordinate among existing agencies. The department of health shall be the designated depository agency for all health data collected pursuant to chapter 492, Laws of 1993. The following data sources shall be developed or made available:

(1) The commission shall coordinate with the secretary of health to utilize data collected by the state center for health statistics including hospital charity care and related data, rural health data, epidemiological data, ethnicity data, social and economic status data, and other data relevant to the commission's responsibilities.

(2) The commission, in coordination with the department of health and the health science programs of the state universities shall develop procedures to analyze clinical and other health services outcome data, and conduct other research necessary for the specific purpose of assisting in the design of the uniform benefits package under chapter 492, Laws of 1993.

(3) The commission shall establish cost data sources and shall require each certified health plan to provide the commission and the department of health with enrollee care and cost information, to include, but not be limited to: (a) Enrollee identifier, including date of birth, sex, and ethnicity; (b) provider identifier; (c) diagnosis; (d) health care services or procedures provided; (e) provider charges, if any; and (f) amount paid. The department shall establish by rule confidentiality standards to safeguard the information from inappropriate use or release.

(4) The commission shall coordinate with the area Indian health service, reservation Indian health service units, tribal clinics, and any urban Indian health service organizations the design, development, implementation, and maintenance of an American Indian-specific health data, statistics information system. The commission rules regarding the confidentiality to safeguard the information from inappropriate use or release shall apply. [1993 c 492 § 262.]

NOTES:

Findings--Intent--1993 c 492: See notes following RCW 43.72.005.

Short title--Severability--Savings--Captions not law--Reservation of legislative power--Effective dates--1993 c 492: See RCW 43.72.910 through 43.72.915.

RCW 70.170.140 Personal health services data and information system. (1) The department is responsible for the implementation and custody of a state-wide personal health services data and information system. The data elements, specifications, and other design features of this data system shall be consistent with criteria adopted by the Washington health services commission. The department shall provide the commission with reasonable assistance in the development of these criteria, and shall provide the commission with periodic progress reports related to the implementation of the system or systems related to those criteria.

(2) The department shall coordinate the development and implementation of the personal health services data and information system with related private activities and with the implementation activities of the data sources identified by the commission. Data shall include: (a) Enrollee identifier, including date of birth, sex, and ethnicity; (b) provider identifier; (c) diagnosis; (d) health services or procedures provided; (e) provider charges, if any; and (f) amount paid. The commission shall establish by rule, confidentiality standards to safeguard the information from inappropriate use or release. The department shall assist the commission in establishing reasonable time frames for the completion of the system development and system implementation. [1993 c 492 § 263.]

NOTES:

Findings--Intent--1993 c 492: See notes following RCW 43.72.005.

Short title--Severability--Savings--Captions not law--Reservation of legislative power--Effective dates--1993 c 492: See RCW 43.72.910 through 43.72.915.

RCW 70.170.900 Effective date--1989 1st ex.s. c 9. See RCW 43.70.910.

RCW 70.170.905 Severability--1989 1st ex.s. c 9. See RCW 43.70.920.

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PART II - METHODS AND STANDARDS FOR ESTABLISHING PAYMENTS FOR PSYCHIATRIC INPATIENT SERVICES PROVIDED IN HOSPITALS OPERATED BY THE STATE OF WASHINGTON

A. INTRODUCTION

The State of Washington's Department of Social and Health Services through its Mental Health Division establishes systems for reimbursement of Medicaid psychiatric inpatient hospital services provided to eligible Medicaid patients in two state operated psychiatric hospitals, Western State Hospital and Eastern State Hospital. This Part describes the reimbursement system for payment of these services. This system is used to reimburse for services provided on or after July 1, 1991.

The reimbursement systems described in this part is limited to the forgoing provider type and are not in replacement of, or substitution for, reimbursement methods for other facility types discussed in Part I of this plan attachment.

The reimbursement system's payments described in this Part are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated hospitals to provide services in conformity with applicable state and federal laws, regulations, and quality and safety standards. Payments are adequate to assure that recipients have reasonable access, taking into account geographic location and reasonable travel time, to inpatient psychiatric hospital services of adequate quality.

The standards used to determine payments take into account the situation of hospitals which serve a disproportionate number of low-income patients with special needs.

The reimbursement system employs the retrospective cost reimbursement method to determine hospital payments. The following plan specifies the methods and standards used to set this payment type, including: definitions; general reimbursement policies; methods for establishing retrospective cost reimbursement; upper payment limits; and administrative policies on provider appeal procedures, uniform cost reporting requirements, and audit requirements.

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B. DEFINITIONS

The terms used in this plan are intended to have their usual meanings unless specifically defined in this section or otherwise in the plan.

1. Department

The Department of Social and Health Services. The department is the State of Washington's state Medicaid agency.

2. Division

Means the Mental Health Division of the Department.

3. HCFA

HCFA means the Department of Health and Human Services' Health Care Financing Administration. HCFA is the federal agency responsible for administering the Medicaid program.

4. Hospital

Hospital means an entity which is licensed as an psychiatric hospital in accordance with applicable State laws and regulations, and which is certified under Title XVIII of the federal Social Security Act.

5. Medicare Adjusted Per-diem

Means the aggregate Medicare Part A costs reported on the Medicare cost report divided by the total Medicare inpatient days reported in the same cost report. Aggregate Medicare costs exclude bad debts and incentive or penalty sums attributable to the Medicare patients reported in the cost report.

6. Medicare Cost Report

Means the annual cost report (Form 2552) filed each year by providers delivering Medicare services as psychiatric hospitals pursuant to 42 CFR 482.60.

7. MHD

MHD means Mental Health Division of the Department.

8. Patient Participation

Means sums found at recipient eligibility determination to paid by the patient toward the cost of care delivered by the psychiatric hospital.

9. Uninsured Indigent Patient

Means an individual who receives hospital inpatient and/or outpatient services at a state psychiatric hospital and the costs of such services are subsidized by state appropriated funds because the individual has no or insufficient insurance or other resources to cover the costs of the services delivered. Medicaid patients of state psychiatric hospitals are considered fully insured through operation of retrospective reimbursement methods described in this plan part.

C. GENERAL REIMBURSEMENT POLICIES

The following section describes the general policies governing the reimbursement system.

1. Retrospective Cost Reimbursement

Payments to state psychiatric hospitals for inpatient services are made on a retrospective cost basis. Under this method Medicaid costs derived from Medicare cost principles are compared to Medicaid interim payments and any differences are paid to or collected from the provider to insure that the final payment is equal to total allowable costs.

2. Outlier Payments

The payment methods of this Part exclude outlier payments because the provider is not obliged to provide care for which reimbursement is not available.

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3. Transfer Policy

For a state psychiatric hospital transferring a recipient to another inpatient facility, the discharge day is claimed for Medicaid service. For a state psychiatric hospital receiving a recipient from another inpatient facility, the admission day is not claimed for Medicaid service.

4. Administrative Days Policy

Administrative days (42 CFR 447.253(b)(1)(B)) are those days of hospital stay wherein psychiatric inpatient level of care is no longer necessary, and an appropriate non-inpatient placement is not available. Administrative days are not reimbursed under the plan.

5. Medicare Crossover Policy

Medicare crossovers refer to hospital patients who are eligible for both Medicare Part A benefits and Medical Assistance. For recipients, the state considers the Medicare payment for each Medicare day to be payment in full. The state will pay the Medicare deductible and co-insurance related to the Medicare psychiatric inpatient hospital services.

In cases where the crossover recipient's Part A benefits including lifetime reserve days are exhausted or not otherwise available, the recipient will shift to full Medicaid status for all necessary future days until discharge.

6. Third-Party Liability Policy

For cases involving third-party liability (TPL), the recovery will be treated as Medicaid patient participation and subtracted from Medicaid interim reimbursement and final Medicaid settlement.

D. RETROSPECTIVE COST REIMBURSEMENT METHOD

This section describes the methodology used for retrospective cost reimbursement for state psychiatric hospitals.

Interim payments to the psychiatric hospitals are made at hospital charge rates computed pursuant to Washington Administrative Code for charges to the general public for services delivered by these hospitals. Recipient patient participation identified at eligibility determination are subtracted from aggregate monthly hospital charges and the reduced sum is paid to the provider.

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Total allowable cost for recipients is computed by multiplying the total Medicaid days by the Medicare Adjusted Per-diem. The product of the computation is reduced by the aggregate of patient participation, and the resulting remainder constitutes total allowable Medicaid costs.

Interim settlements are made upon the provider's completion of the Form HCFA 2552 for each fiscal year. Interim settlement is made by computing total interim payments (Medicaid days x hospital charge rate + interim ancillary charges - patient participation) for the fiscal period and comparing this amount to total allowable cost computed from Form HCFA 2552 (Medicare Adjusted Per-diem x Medicaid days - patient participation). If total allowable cost exceeds total interim payments addition payment is made to the hospital. If total interim payments exceed total allowable costs recovery of excess interim payments is made.

Final settlements are made upon the intermediary's determination of total allowable Medicare costs on Form HCFA 2552 for each fiscal year. Final settlement is made by computing total interim payments (Medicaid days x hospital charge rate + interim ancillary charges - patient participation) for the fiscal period and comparing this amount to total allowable cost computed from Form HCFA 2552 (Medicare Adjusted Per-diem x Medicaid days - patient participation). If total allowable cost exceeds total interim payments addition payment is made to the hospital. If total interim payments exceed total allowable costs recovery of excess interim payments is made. Final settlement will be adjusted for all prior interim settlements and all subsequent adjustments made due to successful appeals to Medicare Intermediary determinations.

E. DISPROPORTIONATE SHARE PAYMENTS

As required by Section 1902(a)(13)(A) and Section 1923(a)(1) of the Social Security Act, the Medicaid reimbursement system takes into account the situation of hospitals which serve a disproportionate number of low-income patients with special needs by making a payment adjust for eligible hospitals. A hospital will receive the following disproportionate share hospital (DSH) payment adjustments if the hospital meets the eligible requirements.

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1. State psychiatric hospitals will be deemed eligible for disproportionate share payment adjustment if its Medicaid patient day utilization is at least one percent and if:

   a. The hospital's Medicaid inpatient utilization rate (as defined by Section 1923(b)(1)(A)) is at least one standard deviation above the mean state Medicaid inpatient utilization rate of hospitals receiving Medicaid payments in the State; or

   b. The hospital's low-income utilization rate (as defined by Section 1923(b)(1)(B)) exceeds 25 percent.

2. The disproportionate share adjustment for inpatient payments as determined under this section of the state plan shall be equal to the lesser of annual net costs of uncompensated services delivered to uninsured indigent patients by each facility as defined below, or each facility's proportionate residual of the annual federal allotment for disproportionate share adjustment payments after subtraction of such payments from the annual federal allotment made under provisions of Part I of this plan attachment.

   a. Annual costs of services delivered to uninsured indigent patients by a facility in a state fiscal year are the product of multiplication of aggregate facility per-diem by total annual inpatient days attributable to uninsured indigent individuals. Aggregate facility per-diem is the quotient of dividing total facility operating expenses by total facility inpatient days reported in Medicare cost report HCFA Form 2552-92 in Worksheet B-1. Total facility operating expenses are those reported in HCFA Form 2552-92, Worksheet G-2. Identification of uninsured indigent patients will be determined with statistical sampling methods as described in the Supplement to this Plan Part.

   Annual net costs of uncompensated services delivered to uninsured indigent patients by a facility in a state fiscal year is the residual of total aggregate annual cost of such patients as defined above, reduced by total revenue received from or on behalf of such patients. This revenue is the amount reported by the department's Office of Financial Recovery as total revenue from all sources but excluding regular Medicaid revenue and receipts of disproportionate share adjustment payments under this plan part, and also excluding Washington State general fund subsidies. Revenue received from or on behalf of uninsured indigent patients will be determined with statistical sampling methods as described in the Supplement to this Plan Part.

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b. For purposes of state fiscal year 1995 under the Omnibus Budget Reconciliation Act of 1993, the amounts computed as annual net costs of services delivered to uninsured indigent patients at Western State Hospital will be doubled, to compute 1995 aggregate annual cost, provided that the Governor of the State of Washington makes certification acceptable to HCFA that the minimum amount will be used for health services, and further provided that this facility is found to have rendered the greatest number of Medicaid inpatient days of all Medicaid inpatient providers in the state during state fiscal year 1994.

3. The disproportionate share adjustment payments shall be made to each hospital in two installments for each federal fiscal year, as described below.

a. The initial installment payment will be the prorated appropriated disproportionate share funding plan for each psychiatric hospital for the state fiscal year but no more than 95 percent of the costs of net uncompensated services to uninsured indigent patients as defined in 2. above for the state fiscal year which ended prior to the beginning of the federal fiscal year and will be paid in the second quarter of each federal fiscal year. The combined appropriated Medicaid disproportionate share hospital payments funding plan shall be prorated between the facilities based on total costs of uncompensated services delivered to uninsured indigent patients as computed above.

b. The final installment will be paid within 120 days after the end of the federal fiscal year, and will be charged against the annual federal allotment for disproportionate share adjustment payments for the prior federal fiscal year as provided in federal regulations. This final installment will be equal to the lessor of; (A) the residual of costs of uncompensated services delivered to uninsured indigent patients for each facility after subtraction of the initial installment paid under a. above for the state fiscal year that ended prior to the beginning of the federal fiscal year, or;